"Slow Down—You Move Too Fast"

By Lt. Kevin Lane,
USS *Nassau* (LHA-4)

Simon and Garfunkel once crooned those words. Here's a mishap that illustrates the need to slow down sometimes or to cut the number of simultaneous evolutions.

Our ship was in the middle of a material inspection. For this inspection, we had to rig and demonstrate nearly every piece of deck gear onboard. Among the items on our list were four unrep stations, heavy-weather lifelines, towing gear, sterngate emergency-raising gear, close-in refueling rig, accommodation ladders, well-deck and flight-deck gear, and small boats. We had spent long hours poring over blueprints and technical manuals to prepare for the inspection, and, by "game day," we were ready.

Our department was stretched thin at the end of the day, as the senior leadership fanned out to break down the "day one" gear and to prepare for day two. The petty officer in charge of the boat boom was a PO2, with just less than one year on board and two years of experience on another ship of the same class. He had been involved in rigging the boat boom the day before.

The boom stuck while being stowed, and a seaman stepped outside the lifelines to see if he could push the boom free with his legs. When it swung out unexpectedly, the semi-protected (by his harness) seaman fell and slammed into the side of the ship. The emergency-response team quickly arrived, had the injured seaman on the deck, and called for an ambulance.

How did something as simple as moving the boat boom from perpendicular to flush with the hull turn into a near-tragic event? First, the boat boom is used infrequently, and, by nature, personnel are not as familiar with its operation as they are with a boat davit or an anchor. In this case, no one onboard could remember the last time we had used the boom.

Second, to keep things moving, the petty officer in charge had stepped away from the detail to stow another line. In his absence, the next senior Sailor, a BM3, took charge.

Third, operational risk management wasn't applied in this case. Did the boom really need someone outside the lifelines to stow it properly? Did it have to be done right now, or could it have waited until someone with more experience was on station? In short, it wasn't worth the risk to proceed because no deadline or operational commitment existed to stow the boom immediately.

The victim made a conscious decision to go outside the lifelines, despite the pleas of fellow junior personnel not to do so. Although he was wearing a safety harness, he connected the hook to the lifelines, instead of a fixed object, like he should have done. He also wasn't wearing a life preserver and hardhat, as required. Had he been wearing both, they may have absorbed some of the force of his fall.

This seaman already had demonstrated that he needed more supervision than others. His CPO, division officer, and department head had counseled him for unsafe behavior (e.g., not wearing a hardhat during crane operations and trying to climb up a ladder that had been secured for repair).

Thankfully, X-rays showed no broken bones and no head, neck or spinal injuries. The Sailor returned to full duty two days later. This incident, however, still weighs heavily on my mind, especially since our ship often simultaneously holds several operations. "Were we just lucky this time?" I keep wondering.

The author was assigned to USS Gunston Hall *(LSD-44) when he wrote this article.*